REFLEXOLOGY HEALTH RECORD

THIS FORM IS TO BE COMPLETED BY THE CLIENT FIRST THEN BY PRACTITIONER FOR INITIAL SESSION

Client			**Date of Birth**			
Telephone	**Home**		**Business**		**Ext**	
Email Address						
Street #		**Street Name**				
City		**Province**		**Postal Code**		
Doctor's Name			**Telephone**			
Doctor's Address						

1. **What is your occupation?** _____

2. **Are you in good health?** **Yes** ☐ **No** ☐ **Explain:** _____

3. **Are you undergoing other therapies?** **Yes** ☐ **No** ☐

   List _____

4. **What else are you doing for your health?** _____

5. **What are your goals/expectations for this session?** _____

6. **When did you last visit your doctor?** _____

   Reason _____

7. **List past surgeries and time of same:** _____

   _____

8. **List past injuries and time of same:** _____

   _____

9. **Are you taking medications? (Please include any vitamins or dietary supplements.)** **Yes** ☐ **No** ☐

   Reasons for taking: _____

10. **Do you sleep well?** **Yes** ☐ **No** ☐

    Explain: _____

11. Do you suffer from anxiety or worry? Yes ☐ No ☐

Explain: _____

12. Is your blood pressure: Normal ☐ High ☐ Low ☐ Stable ☐ Erratic ☐

13. Are you pregnant? Yes ☐ No ☐ If yes, which trimester? 1st ☐ 2nd ☐ 3rd ☐

14. Have you had other pregnancies? Yes ☐ No ☐

15. Do you have allergies/sinus conditions? Yes ☐ No ☐

List: _____

16. Do you have varicose veins? Yes ☐ No ☐

17. Do you wear prostheses (e.g. glasses, contacts, glass eye, artificial joints/limbs, metal plates, pins, or wires, dentures, hearing aids?) Yes ☐ No ☐ Circle which one

18. Is there anything else about your health you wish to discuss? Yes ☐ No ☐

Explain: _____

19. Are you presently experiencing any of the following?

Sunburn ☐ Inflammation ☐ Pain ☐ Headache ☐ Skin Rash ☐ Cold/Flu ☐

Cuts ☐ Bruises ☐ Burns ☐ Decreased Range of Motion ☐

Other: _____

20. Please indicate your consumption level of the following by placing an X in the appropriate column.

	None	Light	Moderate	Heavy
Salt				
Sugar				
Caffeine				
Tobacco				
Alcohol				
Exercise				
Water				

Consent to Receive Treatment

I, the undersigned, consent to reflexology treatment and understand that sessions are for the purpose of stress reduction and relaxation. I may stop the session at anytime, either during the assessment or the treatment.

Reflexologists do not diagnose, prescribe medication for medical or psychological conditions, nor treat for specific conditions.

Signature: _____ **Date:** _____

Do you have problems with any of the following systems?

Endocrine System *(diabetes, hypoglycemia, menopausal problems, hypothyroidism)* **Yes** ☐ **No** ☐

Specify: _____

Urinary System *(kidney disease, urinary problems)* **Yes** ☐ **No** ☐

Specify: _____

Cardiovascular *(high/low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia, etc.)* **Yes** ☐ **No** ☐

Specify: _____

Immune & Lymphatic *(arthritis, chronic fatigue, environmental illness, HIV/AIDS, allergies, etc.)* **Yes** ☐ **No** ☐

Specify: _____

Musculoskeletal *(osteoporosis, fibromyalgia, bursitis, gout, back pain, scoliosis foot, arm or hand problems)* **Yes** ☐ **No** ☐

Specify: _____

Respiratory *(asthmas, emphysema, etc.)* **Yes** ☐ **No** ☐

Specify: _____

Nervous System *(vision, hearing loss/problems, loss of sensation, nerve pain/damage, mental or emotional problems, MS)* **Yes** ☐ **No** ☐

Specify: _____

Reproductive *(PMS, dysmenorrhea, endometriosis, prostate problems, etc.)* **Yes** ☐ **No** ☐

Specify: _____

Digestive *(prolonged constipation, diarrhea, Crohn's Disease, Colitis, diverticulitis, ulcer, etc.)* **Yes** ☐ **No** ☐

Specify: _____

Integumentary (Skin) *(Psoriasis, eczema, warts, etc.)* **Yes** ☐ **No** ☐

Specify: _____

Other

Tuberculosis **Yes** ☐ **No** ☐ Cancer **Yes** ☐ **No** ☐ Aids **Yes** ☐ **No** ☐

Hepatitis **Yes** ☐ **No** ☐ Herpes **Yes** ☐ **No** ☐

If a client is experiencing pain, use the reminder phrase **OL DR FICARA,** when questioning the client to determine the following:

Onset?	**D**uration?	**F**requency?	**C**haracter (dull, sharp, etc.)?	**R**elieving Factors?
Location?	**R**adiation?	**I**ntensity?	**A**ggravating Factors?	**A**ssociated Symptoms?

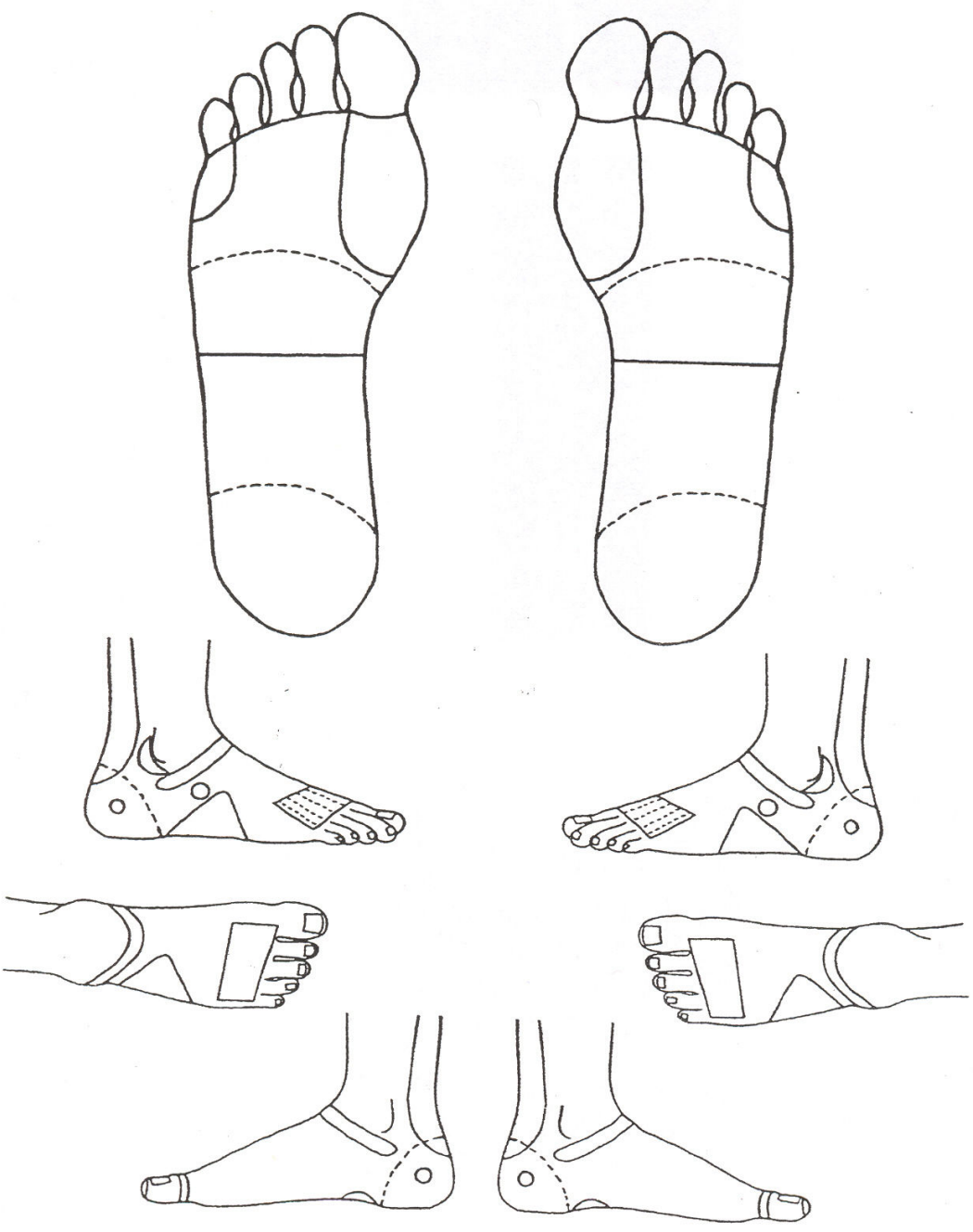
REFLEXOLOGY INITIAL TREATMENT RECORD

NOTE: A GLOSSARY OF SYMBOLS MUST ACCOMPANY THIS PAGE FOR REFERENCE

Client: _____

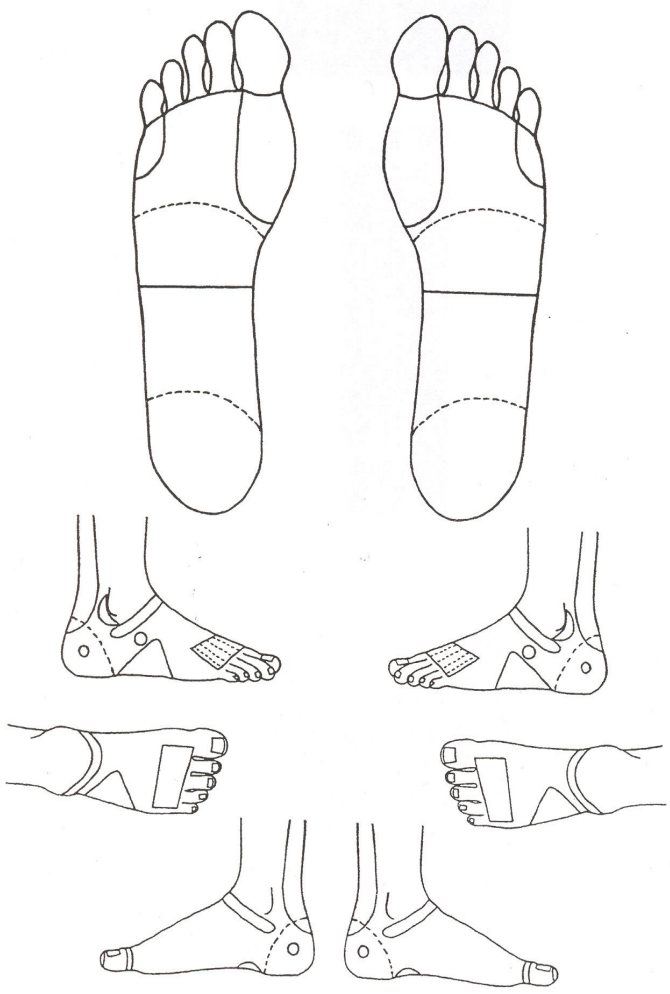
Date of Initial Session: _____

Client Signature: _____



All questions to be completed for each session-use 'Notes' page if needed

Client Name and Client Signature: _____



Date: _____

Felt Last Treatment
Felt Since Treatment
Feels Today
Observations of Client
Foot Observations
Right
Left

Findings During Treatment
Action Taken
Results
Clients Comments
Final Observations
Treatment Notes –

For Health Record & Session Notes